STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 01 COMPLETED		
		155159	B. WING		02/21/2012
NAME OF	PROVIDER OR SUPPLIE	ER.	STRI	EET ADDRESS, CITY, STATE, ZIP CODE	
				0 N CLINTON ST	
SUMMIT	CITY NURSING A	AND REHABILITATION	FOF	RT WAYNE, IN 46805	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFI	CROSS-REFERENCED TO THE APPROPR	RIATE
K0000	REGULATORY O	R ESC IDENTIFY ING INFORMATION)	TAG	BETELENCTY	DATE
10000					
	Δ Life Safety C	Code Recertification	K0000	The creation and submission	n of
	1	nsure Survey was		this Plan Of Correction does	not
		the Indiana State		constitued anadmission by t	
	Department of			provider of any conclusion s forth in the statement of	ет
	I -	ith 42 CFR 483.70(a).		deficiencies, or of any violati	on of
	accordance wi	iui 72 CFN 403.70(d).		regulation. This provider	
	Survey Date:	02/21/12		respectfully requests that the	e
	Survey Date.	02/21/12		2567 Plan Of Correction be considered the letter of cred	ible
	Facility Neverla	000070		allegation and request a pos	
	Facility Number			survey review on or after Ma	
	Provider Numl			22, 2012.	
	AIM Number:	100266160			
	C A				
	-	y Kelley, Life Safety			
	Code Specialis	st			
	At this Life Car	fety Code survey,			
	Summit City N	was found not in			
		ith Requirements for			
	Participation in				
	Medicare/Med				
	I	'0(a), Life Safety			
		the 2000 edition of			
	the National F				
		IFPA) 101, Life Safety			
		hapter 19, Existing			
		ccupancies and 410			
	IAC 16.2.				
	I -	facility with a			
	basement was	determined to be of			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL	
AND FLAN	OF CORRECTION	155159		LDING	01	02/21/	
		.00.00	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	02/2 !!	
NAME OF P	PROVIDER OR SUPPLIER	2		1	CLINTON ST		
		ND REHABILITATION			VAYNE, IN 46805		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
		onstruction and was		0			3.112
		d. The facility has					
		stem with smoke					
		e corridor, areas					
		rridor and battery					
	· · ·	e detectors in the					
	-	The facility has a					
		and had a census of					
	47 at the time						
		/ -					
	Quality Review by	Robert Booher, Life Safety					
	Code Specialist-Me	dical Surveyor on 02/27/12.					
	The facility was						
	compliance wit						
	aforementione	_					
		is evidenced by the					
	following:						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPL	
		155159	B. WIN	IG		02/21/	2012
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE CLINTON ST		
		ND REHABILITATION	_		VAYNE, IN 46805		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	,	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ΓE	COMPLETION DATE
		LSC IDENTIFFING INFORMATION)		TAG	BELIEFE.		DATE
K0018 SS=E	Doors protecting than required en exits, or hazardo doors, such as the solid-bonded corresisting fire for a sprinklered build resist the passage impediment to the Doors are provide keeping the door meeting 19.3.6.3 Roller latches are regulations in all Based on observite corridor kitchenettes are porches. This could affect an main dining roof Finding included Based on observite Maintenance D 02/21/12 at 1: dining room has a kitchenette or room. These reand were separdining room by	facility failed to or doors to 1 of 1 and 1 of 1 sun deficient practice y resident in the om.	K00	018	Automatic Supervised Smoke detectors will be installed in th Sun Porch and Kitchenette located just off the main dining room on the second floor. The installation will be performed by professionals and will meet the guidelines set forth within the I Safety Code Standards. This corrective action will ensure the the Sun Porch and Kitchenette will remain in compliance with Safety Code Standards.	y e Life at	03/19/2012
	separated from	the corridor. This					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/12/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155159	A. BUILDING B. WING	01	— 02/21	LETED //2012
SUMMIT		ND REHABILITATION	2940 N FORT V	ADDRESS, CITY, STATE, ZIP C CLINTON ST WAYNE, IN 46805	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	REGULATORY OR was acknowled	ded by the upervisor at the		CROSS-REFERENCED TO THE ADEFICIENCY)	APPROPRIATE	

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Event ID: SXTS21

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155150		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED
	155159	B. WING		02/21/2012
	PROVIDER OR SUPPLIER CITY NURSING AND REHABILITATION	2940 N	ADDRESS, CITY, STATE, ZIP CODE I CLINTON ST WAYNE, IN 46805	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K0029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 basement Housekeeping storage rooms and 1 of 1 resident rooms used for storage of combustibles, measuring over 50 square feet in size, were provided with a self closing device. This deficient practice was not in a resident care area but could affect any number of staff and 3 residents on A hall. Findings include: a. Based on observation with the Maintenance Supervisor on 02/21/12 at 2:10 p.m., the corridor door to the basement Housekeeping storage room with combustible storage such as cleaning chemicals, blankets and	K0029	Self closing device was installed on the Housekeeping Storage room and room 106 doors. This corrective action ensure that the closing of the doors meets Life Safety Code standards.	will se

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	ILDING	01	COMPL	
		155159	B. WIN			02/21/	2012
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
OLINANAIT	OLTY NILIDOING A	ND DELIABILITATION			CLINTON ST		
SUMMIT	CITY NURSING A	ND REHABILITATION		FORTV	VAYNE, IN 46805		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	NCY MUST BE PERCEDED BY FULL B. I. S.C. IDENTIFYING INFORMATION		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1 -	ns lacked a self					
	_	. The Housekeeping					
	_	measured twenty					
		irty four feet in size.					
		were provided by					
	the Maintenan						
		bservation with the					
	Maintenance S	•					
		:45 p.m., resident					
		being used to store					
		such as at least					
	1 '	rd boxes of new					
		the door lacked a					
	self closing de	vice. The room					
	measured eigl	nteen feet by eleven					
	feet. Measure	ments were					
	provided by th	ne Maintenance					
	Supervisor.						
	3.1-19(b)						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/12/2012 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155159			LDING	ONSTRUCTION 01	(X3) DATE : COMPL 02/21 /	ETED
	PROVIDER OR SUPPLIER	ND REHABILITATION		2940 N	ADDRESS, CITY, STATE, ZIP CODE CLINTON ST WAYNE, IN 46805		
			1		T		(7/5)
(X4) ID PREFIX		FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	``	LSC IDENTIFYING INFORMATION)	TAG CROSS-REFERENCED TO THE APPROP		TE	DATE	
K0038 SS=F	NFPA 101 LIFE SAFETY C Exit access is an readily accessible with section 7.1. Based on observing the mean of through 6 of 7 accessible for reclinical diagnost specialized sector LSC 19.2.2.2.4 within a require shall not be equire shall not be equire shall not be equire shall not delayed permitted in he occupancies, of care occupancies, of care occupancies, of care occupancies or require specialismeasures for the provided staff of such doors at a deficient practice resident without diagnoses requires requires requires the control of the cont	ODE STANDARD ranged so that exits are e at all times in accordance 19.2.1 rvation and acility failed to ans of egress exits was readily esidents without a sis requiring urity measures. requires doors ed means of egress uipped with a latch quires the use of a an the egress side. I requires rrangements d egress shall be ealth care r portions of health es, where the of the residents zed security heir safety, can readily unlock all times. This ce could affect any at a medical airing security heir g through all exit	Koo		The code for exit access posted at doors for accessibili all times. This corrective action will ensure the means of egret through exits is readily access for residents without a clinical diagnosis requiring specialized security measures as well as family members and visitors.	ty at n ss sible	03/06/2012

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Event ID: SXTS21

Facility ID: 000079

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC	01	(X3) DATE SURVEY COMPLETED
	155159	A. BUILDING B. WING		02/21/2012
			ADDRESS, CITY, STATE, ZIP CODE	
	PROVIDER OR SUPPLIER	2940 N	CLINTON ST	
SUMMIT	CITY NURSING AND REHABILITATION	FORT V	WAYNE, IN 46805	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE COMPLETION DATE
1710	Findings include:	1710		DATE
	- manigs include.			
	Based on observation on with the			
	Maintenance Supervisor on			
	02/21/12 from 12:00 p.m. to			
	2:15 p.m., with the exception of			
	the Auguste's Cottage exit, all			
	other exit doors were magnetically			
	locked and could be opened by			
	entering a code, but the code was			
	not posted. The Maintenance			
	Supervisor acknowledged the code			
	was not posted at this time.			
	2.1.10(1)			
	3.1-19(b)			

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Event ID: SXTS21

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	ECONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPL	ETED
		155159	B. WING		02/21/	/2012
NAME OF F	PROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP COD	E	
NAME OF F	KOVIDER OR SUPPLIER		2940	N CLINTON ST		
	CITY NURSING AN	ND REHABILITATION	FOR	T WAYNE, IN 46805		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	TION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)		COMPLETION
TAG K0143	NFPA 101	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCT)		DATE
SS=E		ODE STANDARD				
00-L	Transferring of o					
	-					
		m any portion of a facility				
		are housed, examined, or aration of a fire barrier of				
	1-hour fire-resist					
	(b) in an area tha	at is mechanically ventilated,				
		has ceramic or concrete				
	flooring; and					
	(c) in an area po	sted with signs indicating that				
		ccurring, and that smoking in				
		rea is not permitted in				
		NFPA 99 and the s Association. 8.6.2.5.2				
	·		K0143	The Transferring of osy	nen .	03/16/2012
	Based on obser		110115	room is being relocated to	•	03/10/2012
	interview, the f				area that meets the Life Safety	
		stored in 1 of 1		Code Standards. This cor		
	sprinklered oxy	• =		action will ensure that oxy transferring room will rem		
	_	er locations was		compliance of Life Safety		
	· -	any portion of a		Standards.		
	facility wherein					
		ned, or treated by a				
	-	fire barrier of 1				
		ive construction				
		I fixtures were at				
		ove the floor. NFPA				
		requires storage				
	for nonflamma	5				
		-3.1.1.2. NFPA 99,				
		requires electrical				
	•	nes and outlets in				
	oxygen storage					
	installed in fixe	ed locations not less				

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155159		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 02/21/2012
	PROVIDER OR SUPPLIE	R ND REHABILITATION	2940 N	ADDRESS, CITY, STATE, ZIP CODE CLINTON ST WAYNE, IN 46805	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	avoid physical deficient pract residents near	om in the event of			
	Maintenance S 02/21/12 at 1 oxygen transfellarge liquid ox placed in the relectrical light wall less than floor. Addition Maintenance S unable to confi	2:55 p.m., the erring room had two ygen storage tanks oom with two switches on the five feet above the hally, the			

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED
		155159	B. WING		02/21/2012
NAME OF I	DOLUBED OF GUIDN IEI		STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF E	PROVIDER OR SUPPLIE	R	2940 N	CLINTON ST	
SUMMIT	CITY NURSING A	ND REHABILITATION	FORT	WAYNE, IN 46805	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
K0147 SS=D	NFPA 101	CODE STANDARD			
33-0		and equipment is in			
		NFPA 70, National			
	Electrical Code.				
	Based on obse	rvation and	K0147	The proper wiring has been	
	interview, the	facility failed to		installed to the pump and light in the maintenance shop. This	<u> </u>
	ensure 2 of 2 f	flexible cords such		installation was completed by	
	as an extensio	n cord were not		professionals that perform task	k
	used as a subs	titute for fixed		according to the National	
	wiring. LSC 9.			Electrical Codes. This correcti	
	1	g and equipment to		action will ensure the electrica equipment remains within the	
		FPA 70, National		Safety Code standards.	Liic
		, 1999 Edition.			
		le 400-8 requires,			
		ally permitted,			
		and cables shall not			
		ubstitute for fixed			
	wiring of a stru				
	deficient pract	ice was not in a			
	resident care a	rea but could affect			
	any number of	staff.			
	Finalina a in alua	J.,			
	Findings includ	ue.			
	Based on an ol	oservation with the			
	Maintenance S	upervisor on			
	02/21/12, two	·			
		ls were plugged in			
		power to a sump			
	1	ght in the basement			
	1	hop. This was			
		•			
	_	by the Maintenance			
	Supervisor at t	ne time of			

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PRINTED: 03/12/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED
		155159	B. WING		02/21/2012
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	
				CLINTON ST	
SUMMIT		ND REHABILITATION	FORT	WAYNE, IN 46805	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	observations.				
	3.1-19(b)				

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